D. LIVING ARRANGEMENTS AND SUPPORT

Note any changes in patient's environment, living situation, or supportive assistance:

___ No changes

___ Changes present; describe:

E. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT

1. **EYES:**

(M0390) Vision with corrective lenses if the patient usually wears them:

- ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

2. Identify and describe any changes or problems with:

Ears:

Mouth/throat:

Nose:

3. **MUSCULOSKELETAL, NEUROLOGICAL:**

Patient's perceived pain level (scale value 0-10) _____

(M0420) Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

Comments on pain management:

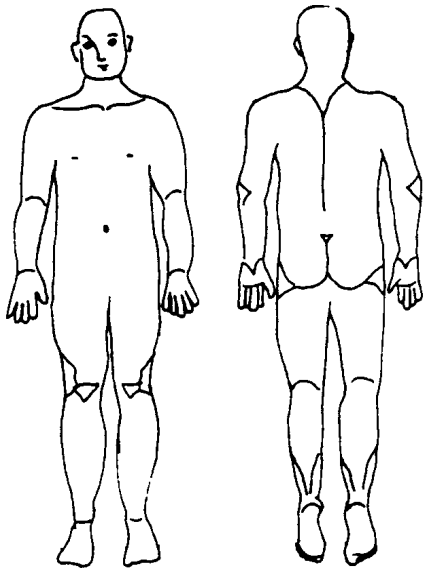
Identify and describe any neurological or musculoskeletal changes or problems assessed:

___ Cognitive functioning	___ Speech/language	___ Muscle strength/weakness	___ Joint function	___ Balance, coordination
___ Level of consciousness	___ Sensation	___ Range of motion	___ Posture	___ Dizziness

COMMENTS:

4. **INTEGUMENT:**

a. Skin condition (Record type # on body area. Indicate size to right of numbered category.)



	Type	Size
1.	Lesions	
2.	Bruises	
3.	Masses	
4.	Scars	
5.	Stasis Ulcers	
6.	Pressure Ulcers	
7.	Surgical Wounds	
8.	Other (specify) _____	

b. **(M0440)** Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."
☐ 0 - No **[If No, go to *Section 5 - Cardiorespiratory*]**
☐ 1 - Yes

c. **(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage. If the patient has no pressure ulcers at a given stage, circle "0" for that stage.)**

Pressure Ulcer Stages	Number of Pressure Ulcers				
a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.).	0	1	2	3	4 or more
e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes					

(M0460) Skip this item if patient has no pressure ulcers. **Stage of Most Problematic (Observable) Pressure Ulcer:**
☐ 1 - Stage 1
☐ 2 - Stage 2
☐ 3 - Stage 3
☐ 4 - Stage 4
☐ NA - No observable pressure ulcer

Describe current status of pressure ulcer(s).

Describe current treatment approach(es) for pressure ulcer(s).

d. Stasis Ulcers

(M0476) Status of Most Problematic (Observable) Stasis Ulcer: Go to 4e if patient has no stasis ulcers.
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable stasis ulcer

Describe current treatment approach(es) for stasis ulcer(s).

e. Surgical Wounds

(M0488) Status of Most Problematic (Observable) Surgical Wound: Go to 4f if patient has no surgical wounds.
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable surgical wound

Describe current treatment approach(es) for surgical wound(s).

f. Other Wounds Requiring Treatment

Type of Wound:

Status:

Current treatment Approach(es):

5. **CARDIORESPIRATORY:** Temperature _____ Respirations _____

BLOOD PRESSURE: Lying _____ Sitting _____ Standing _____

PULSE: Apical rate _____ Radial rate _____ Rhythm _____ Quality _____

___ Edema ___ Varicosities ___ Pacemaker _____ (Date of last battery change)

___ Chest pain ___ Fatigues easily ___ Other

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?
- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

___ Orthopnea (# of pillows _____) ___ Cough _____ (Describe) ___ Breath sounds _____ (Describe)

___ Cyanosis ___ Sputum _____ (Character and amount) ___ Other _____ (Specify)

COMMENTS:

6. **GENITOURINARY TRACT:**

(M0530) Skip this item if patient has no urinary incontinence or does have a urinary catheter. **When** does **Urinary Incontinence** occur?
- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

COMMENTS: (e.g., appliances and care, bladder programs, catheter type and care)

7. **GASTROINTESTINAL TRACT:**

(M0540) Bowel Incontinence Frequency:
- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?
- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

COMMENTS: (e.g., bowel function, use of laxatives or enemas, bowel program, GI status, nutritional status)

8. **EMOTIONAL/BEHAVIORAL STATUS:**

(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark **all that apply.)**
- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

Identify and describe any changes or problems:

___ Anxiety

___ Mood (depression, mania, lability)

___ Sleep disturbances

___ Agitation

___ Other

COMMENTS: (describe other related behaviors or symptoms)

9. **OTHER UPDATED ASSESSMENTS:**

F. LIFE SYSTEM PROFILE: For M0650-M0700, record what the patient currently is *able to do*.

1. **(M0650) Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
   - ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
   - ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on upper body clothing.
   - ☐ 3 - Patient depends entirely upon another person to dress the upper body.

2. **(M0660) Ability to Dress Lower Body** (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
   - ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
   - ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
   - ☐ 3 - Patient depends entirely upon another person to dress lower body.

3. **(M0670) Bathing:** Ability to wash entire body. **Excludes grooming (washing face and hands only).**
   - ☐ 0 - Able to bathe self in shower or tub independently.
   - ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently.
   - ☐ 2 - Able to bathe in shower or tub with the assistance of another person:
     (a) for intermittent supervision or encouragement or reminders, OR
     (b) to get in and out of the shower or tub, OR
     (c) for washing difficult to reach areas.
   - ☐ 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
   - ☐ 4 - Unable to use the shower or tub and is bathed in bed or bedside chair.
   - ☐ 5 - Unable to effectively participate in bathing and is totally bathed by another person.

4. **(M0680) Toileting:** Ability to get to and from the toilet or bedside commode.
   - ☐ 0 - Able to get to and from the toilet independently with or without a device.
   - ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
   - ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
   - ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
   - ☐ 4 - Is totally dependent in toileting.

5. **(M0690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.
   - ☐ 0 - Able to independently transfer.
   - ☐ 1 - Transfers with minimal human assistance or with use of an assistive device.
   - ☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
   - ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
   - ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
   - ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

6. **(M0700) Ambulation/Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
   - ☐ 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
   - ☐ 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
   - ☐ 2 - Able to walk only with the supervision or assistance of another person at all times.
   - ☐ 3 - Chairfast, unable to ambulate but is able to wheel self independently.
   - ☐ 4 - Chairfast, unable to ambulate and is unable to wheel self.
   - ☐ 5 - Bedfast, unable to ambulate or be up in a chair.

7. Identify and describe any changes or problems with:

   ___ Personal hygiene ___ Meal preparation ___ Medication management

   ___ Feeding, eating ___ Laundry, shopping, housekeeping

Client's Name:

Client Record No.

G. THERAPY NEED

(M0825) Therapy Need: Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Not applicable

H. UPDATE TO ANY OTHER ASSESSMENT AREAS:

I. CONCLUSIONS/IMPRESSIONS AND SKILLED INTERVENTIONS PERFORMED THIS VISIT:

Date of Assessment: _____ Signature of Assessor: _____

TRANSFER TO INPATIENT FACILITY

(Page 1 of 2)

Client's Name:

Client Record No.

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

1. **(M0080) Discipline of Person Completing Assessment:**
   - ☐ 1 - RN
   - ☐ 2 - PT
   - ☐ 3 - SLP/ST
   - ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**
   __ __ – __ __ – __ __ __ __
   m m d d y y y y

3. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- ☐ **6 - Transferred to an inpatient facility—patient not discharged from agency**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency**

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency

B. EMERGENT CARE

1. **(M0830) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**
   - ☐ 0 - No emergent care services **[If no emergent care, go to *Section C #1 - Inpatient Facility*]**
   - ☐ 1 - Hospital emergency room (includes 23-hour holding)
   - ☐ 2 - Doctor's office emergency visit/house call
   - ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
   - ☐ UK - Unknown **[If UK, go to *Section C #1 - Inpatient Facility*]**

2. **(M0840) Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
   - ☐ 3 - Injury caused by fall or accident at home
   - ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
   - ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
   - ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain
   - ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 8 - GI bleeding, obstruction
   - ☐ 9 - Other than above reasons
   - ☐ UK - Reason unknown

C. INPATIENT FACILITY ADMISSION OR DISCHARGE FROM HOME CARE

1. **(M0855)** To which **Inpatient Facility** has the patient been admitted?
   - ☐ 1 - Hospital **[Go to *#2 - Hospital Reason*]**
   - ☐ 2 - Rehabilitation facility **[Go to *#5 - Most Recent Home Visit Date*]**
   - ☐ 3 - Nursing home **[Go to *#4 - Reason Admitted Nursing Home*]**
   - ☐ 4 - Hospice **[Go to *#5 - Most Recent Home Visit Date*]**

2. **(M0890)** If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?
   - ☐ 1 - Hospitalization for emergent (unscheduled) care
   - ☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
   - ☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
   - ☐ UK - Unknown

3. **(M0895) Reason for Hospitalization: (Mark all that apply.)**
   - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
   - ☐ 2 - Injury caused by fall or accident at home
   - ☐ 3 - Respiratory problems (SOB, infection, obstruction)
   - ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
   - ☐ 5 - Hypo/Hyperglycemia, diabetes out of control
   - ☐ 6 - GI bleeding, obstruction
   - ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
   - ☐ 8 - Myocardial infarction, stroke
   - ☐ 9 - Chemotherapy
   - ☐ 10 - Scheduled surgical procedure
   - ☐ 11 - Urinary tract infection
   - ☐ 12 - IV catheter-related infection
   - ☐ 13 - Deep vein thrombosis, pulmonary embolus
   - ☐ 14 - Uncontrolled pain
   - ☐ 15 - Psychotic episode
   - ☐ 16 - Other than above reasons

Go to *#5 - Most Recent Home Visit Date*

4. **(M0900)** For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**
   - ☐ 1 - Therapy services
   - ☐ 2 - Respite care
   - ☐ 3 - Hospice care
   - ☐ 4 - Permanent placement
   - ☐ 5 - Unsafe for care at home
   - ☐ 6 - Other
   - ☐ UK - Unknown

5. **(M0903) Date of Last (Most Recent) Home Visit:**

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

6 **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

7. Was the patient **Discharged** from the **Agency?**
   - ☐ No **[If No, STOP here]**
   - ☐ Yes **[If Yes, go to *Section D*]**

D. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE

1. Identified Problem	Interventions	Current Status

2. Overall Status at Discharge:

Copy of Summary to ☐ Referral Source ☐ Attending Physician

Date of Assessment: _____ Signature of Assessor: _____

DISCHARGE ASSESSMENT

Client's Name:

Client Record No.

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as Needed

1. **(M0080) Discipline of Person Completing Assessment:**
   - ☐ 1 - RN
   - ☐ 2 - PT
   - ☐ 3 - SLP/ST
   - ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**
   __ __ – __ __ – __ __ __ __
   m m d d y y y y

3. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- ☐ **6 - Transferred to an inpatient facility—patient not discharged from agency [Go to *M00830*]**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency [Go to *M0830*]**

Discharge from Agency — Not to an Inpatient Facility
- ☐ **8 - Death at home [Go to *M0906*]**
- ☐ **9 - Discharge from agency**

4. **(M0200) Medical or Treatment Regimen Change Within Past 14 Days:** Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?
   - ☐ 0 - No **[If No, go to #7]**
   - ☐ 1 - Yes

5. **(M0210)** List the patient's **Medical Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical or V-codes):

Changed Medical Regimen Diagnosis	ICD-9-CM
a. _____	(__ __ __ . __ __)
b. _____	(__ __ __ . __ __)
c. _____	(__ __ __ . __ __)
d. _____	(__ __ __ . __ __)

6. **(M0220) Conditions Prior to Medical or Treatment Regimen Change Within Past 14 Days:** If this patient experienced a change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the change in medical or treatment regimen.
   (Mark all that apply.)
   - ☐ 1 - Urinary incontinence
   - ☐ 2 - Indwelling/suprapubic catheter
   - ☐ 3 - Intractable pain
   - ☐ 4 - Impaired decision-making
   - ☐ 5 - Disruptive or socially inappropriate behavior
   - ☐ 6 - Memory loss to the extent that supervision required
   - ☐ 7 - None of the above

7. **Patient/Family Knowledge and Coping Level Regarding Present Illness**:

   Patient:

   Family:

B. (M0250) THERAPIES the patient receives at home: (Mark all that apply.)

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

C. PROGNOSIS

(M0280) Life Expectancy: (Physician documentation is not required.)
- ☐ 0 - Life expectancy is greater than 6 months
- ☐ 1 - Life expectancy is 6 months or fewer

D. (M0290) HIGH RISK FACTORS characterizing this patient: (Mark all that apply.)

- ☐ 1 - Heavy smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above

E. LIVING ARRANGEMENTS

1. **(M0300) Current Residence**:
   - ☐ 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
   - ☐ 2 - Family member's residence
   - ☐ 3 - Boarding home or rented room
   - ☐ 4 - Board and care or assisted living facility
   - ☐ 5 - Other (specify) _____
3. Note any changes in patient's environment or safety:
   - __ No changes
   - __ Changes present, describe:

2. **(M0340) Patient Lives With: (Mark all that apply.)**
   - ☐ 1 - Lives alone
   - ☐ 2 - With spouse or significant other
   - ☐ 3 - With other family member
   - ☐ 4 - With a friend
   - ☐ 5 - With paid help (other than home care agency staff)
   - ☐ 6 - With other than above

F. SUPPORTIVE ASSISTANCE

1. **Names of Persons/Organizations Providing Assistance:**

2. **(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)**
   - ☐ 1 - Relatives, friends, or neighbors living outside the home
   - ☐ 2 - Person residing in the home (EXCLUDING paid help)
   - ☐ 3 - Paid help
   - ☐ 4 - None of the above **[If None of the above, go to *Section G - Review of Systems/Physical Assessment*]**
3. **(M0360) Primary Caregiver** taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):
   - ☐ 0 - No one person **[If No one person, go to *Section G - Review of Systems/Physical Assessment*]**
   - ☐ 1 - Spouse or significant other
   - ☐ 2 - Daughter or son
   - ☐ 3 - Other family member
   - ☐ 4 - Friend or neighbor or community or church member
   - ☐ 5 - Paid help

Comments regarding assistance available to the patient:

4. **(M0370) How Often** does the patient receive assistance from the primary caregiver?
   - ☐ 1 - Several times during day and night
   - ☐ 2 - Several times during day
   - ☐ 3 - Once daily
   - ☐ 4 - Three or more times per week
   - ☐ 5 - One to two times per week
   - ☐ 6 - Less often than weekly
5. **(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)**
   - ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
   - ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
   - ☐ 3 - Environmental support (housing, home maintenance)
   - ☐ 4 - Psychosocial support (socialization, companionship, recreation)
   - ☐ 5 - Advocates or facilitates patient's participation in appropriate medical care
   - ☐ 6 - Financial agent, power of attorney, or conservator of finance
   - ☐ 7 - Health care agent, conservator of person, or medical power of attorney

G. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT

1. **ORAL:**

(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):
- ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

2. Identify and describe any changes or problems with:

   Eyes:

   Ears:

   Mouth and Throat:

   Nose:

3. **MUSCULOSKELETAL/NEUROLOGICAL:**

   Patients perceived pain level (scale value 0-10) _____

   (M0420) Frequency of Pain interfering with patient's activity or movement:
   - ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
   - ☐ 1 - Less often than daily
   - ☐ 2 - Daily, but not constantly
   - ☐ 3 - All of the time

   Comments on pain management:

   (M0430) Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?
   - ☐ 0 - No
   - ☐ 1 - Yes

Identify and describe any neurological or musculoskeletal changes or problems assessed:

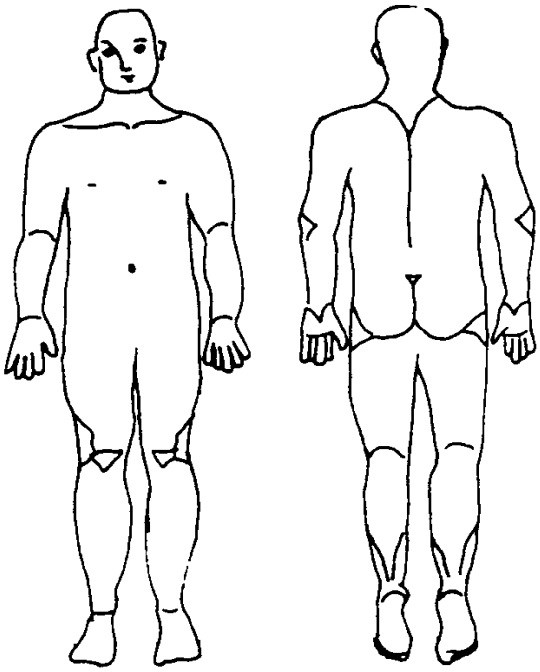
___ Sensation ___ Range of motion ___ Posture ___ Dizziness

___ Muscle strength/weakness ___ Joint function ___ Balance, coordination

Comments:

4. **INTEGUMENT:**

a. Skin condition (Record type # on body area. Indicate size to right of numbered category.)



	Type	Size
1.	Lesions	
2.	Bruises	
3.	Masses	
4.	Scars	
5.	Stasis Ulcers	
6.	Pressure Ulcers	
7.	Surgical Wounds	
8.	Other (specify) _____	

b. **(M0440)** Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."
- ☐ 0 - No **[If No, go to *Section 5 - Cardiorespiratory*]**
- ☐ 1 - Yes

c. **(M0445)** Does this patient have a **Pressure Ulcer**?
- ☐ 0 - No **[If No, go to *#4.d - Stasis Ulcer*]**
- ☐ 1 - Yes

(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

Pressure Ulcer Stages	Number of Pressure Ulcers				
a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.).	0	1	2	3	4 or more
e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes					

(M0460) Stage of Most Problematic (Observable) Pressure Ulcer:
- ☐ 1 - Stage 1
- ☐ 2 - Stage 2
- ☐ 3 - Stage 3
- ☐ 4 - Stage 4
- ☐ NA - No observable pressure ulcer

(M0464) Status of Most Problematic (Observable) Pressure Ulcer:
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable pressure ulcer

Describe current treatment approach(es) for pressure ulcer(s):

d. **(M0468)** Does this patient have a **Stasis Ulcer**?
- ☐ 0 - No **[If No, go to *#4.e - Surgical Wound*]**
- ☐ 1 - Yes

(M0470) Current Number of Observable Stasis Ulcer(s):
- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

(M0474) Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?
- ☐ 0 - No
- ☐ 1 - Yes

(M0476) Status of Most Problematic (Observable) Stasis Ulcer:
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable stasis ulcer

Describe current treatment approach(es) for stasis ulcer(s):

e. **(M0482)** Does this patient have a **Surgical Wound**?
- ☐ 0 - No **[If No, go to *Section 5 - Cardiorespiratory*]**
- ☐ 1 - Yes

(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)
- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

(M0486) Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?
- ☐ 0 - No
- ☐ 1 - Yes

(M0488) Status of Most Problematic (Observable) Surgical Wound:
- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable surgical wound

Describe current treatment approach(es) for surgical wound(s):

COMMENTS: Describe wounds not identified above, include type, location, and size of each wound; current status; and treatment approach(es):

5. **CARDIORESPIRATORY:** Temperature _____ Respirations _____

BLOOD PRESSURE: Lying _____ Sitting _____ Standing _____

PULSE: Apical rate _____ Radial rate _____ Rhythm _____ Quality _____

___ Edema ___ Varicosities ___ Pacemaker _____
(Date of last battery change)

___ Chest pain ___ Fatigue easily ___ Other _____
(Describe)

COMMENTS:

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?
- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

___ Orthopnea (# pillows ___) ___ Cough ___ Breath Sounds _____
(Describe)

___ Cyanosis ___ Sputum _____ ___ Other (describe) _____
(character and amount)

(M0500) Respiratory Treatments utilized at home: **(Mark all that apply.)**
- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous positive airway pressure
- ☐ 4 - None of the above

COMMENTS:

6. **GENITOURINARY TRACT:**

(M0510) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment

(M0520) Urinary Incontinence or Urinary Catheter Presence:
- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[If No, go to *Section 7 - Gastrointestinal Tract*]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to *Section 7 - Gastrointestinal Tract*]**

(M0530) When does **Urinary Incontinence** occur?
- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

COMMENTS (e.g., appliances and care, bladder program, catheter type and care):

7. **GASTROINTESTINAL TRACT:**

(M0540) Bowel Incontinence Frequency:
- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination

COMMENTS (e.g., bowel function, use of laxatives or enemas, bowel program, G.I. status, nutritional status):

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days) necessitated a change in medical or treatment regimen?
- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy did necessitate change in medical or treatment regimen.

8. **NEURO/EMOTIONAL/BEHAVIORAL STATUS:**

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)
- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M0570) When Confused (Reported or Observed):
- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

(M0580) When Anxious (Reported or Observed):
- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)
- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)
- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):
- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

(M0630) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?
- ☐ 0 - No
- ☐ 1 - Yes

COMMENTS (describe other related behaviors or symptoms, e.g., weight loss, sleep disturbances, coping skills):

9. **OTHER UPDATED ASSESSMENTS:**

H. LIFE SYSTEM PROFILE: For M0640-M0800, record what the patient currently is *able to do*.

1. **(M0640) Grooming:** Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
   - ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
   - ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
   - ☐ 2 - Someone must assist the patient to groom self.
   - ☐ 3 - Patient depends entirely upon someone else for grooming needs.

2. **(M0650) Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
   - ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
   - ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on upper body clothing.
   - ☐ 3 - Patient depends entirely upon another person to dress the upper body.

3. **(M0660) Ability to Dress Lower Body** (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
   - ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
   - ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
   - ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
   - ☐ 3 - Patient depends entirely upon another person to dress lower body.

4. **(M0670) Bathing:** Ability to wash entire body. **Excludes grooming (washing face and hands only).**
   - ☐ 0 - Able to bathe self in shower or tub independently.
   - ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently.
   - ☐ 2 - Able to bathe in shower or tub with the assistance of another person:
     (a) for intermittent supervision or encouragement or reminders, OR
     (b) to get in and out of the shower or tub, OR
     (c) for washing difficult to reach areas.
   - ☐ 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
   - ☐ 4 - Unable to use the shower or tub and is bathed in bed or bedside chair.
   - ☐ 5 - Unable to effectively participate in bathing and is totally bathed by another person.

5. **(M0680) Toileting:** Ability to get to and from the toilet or bedside commode.
   - ☐ 0 - Able to get to and from the toilet independently with or without a device.
   - ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
   - ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
   - ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
   - ☐ 4 - Is totally dependent in toileting.

6. **(M0690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.
   - ☐ 0 - Able to independently transfer.
   - ☐ 1 - Transfers with minimal human assistance or with use of an assistive device.
   - ☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
   - ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
   - ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
   - ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

7. **(M0700) Ambulation/Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
   - ☐ 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
   - ☐ 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
   - ☐ 2 - Able to walk only with the supervision or assistance of another person at all times.
   - ☐ 3 - Chairfast, unable to ambulate but is able to wheel self independently.
   - ☐ 4 - Chairfast, unable to ambulate and is unable to wheel self.
   - ☐ 5 - Bedfast, unable to ambulate or be up in a chair.

8. **(M0710) Feeding or Eating:** Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**
   - ☐ 0 - Able to independently feed self.
   - ☐ 1 - Able to feed self independently but requires:
     (a) meal set-up; OR
     (b) intermittent assistance or supervision from another person; OR
     (c) a liquid, pureed or ground meat diet.
   - ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
   - ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
   - ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
   - ☐ 5 - Unable to take in nutrients orally or by tube feeding.

9. **(M0720) Planning and Preparing Light Meals** (e.g., cereal, sandwich) or reheat delivered meals:
   - ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
     (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
   - ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
   - ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.

10. **(M0730) Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).
   - ☐ 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
   - ☐ 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
   - ☐ 2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.

11. **(M0740) Laundry:** Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.
   - ☐ 0 - (a) Able to independently take care of all laundry tasks; OR
     (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).
   - ☐ 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
   - ☐ 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.

12. **(M0750) Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.
   - ☐ 0 - (a) Able to independently perform all housekeeping tasks; OR
     (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
   - ☐ 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
   - ☐ 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
   - ☐ 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
   - ☐ 4 - Unable to effectively participate in any housekeeping tasks.

13. **(M0760) Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.
   - ☐ 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR
     (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
   - ☐ 1 - Able to go shopping, but needs some assistance:
     (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR
     (b) Unable to go shopping alone, but can go with someone to assist.
   - ☐ 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
   - ☐ 3 - Needs someone to do all shopping and errands.

14. **(M0770) Ability to Use Telephone:** Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.
   - ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
   - ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
   - ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
   - ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
   - ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
   - ☐ 5 - Totally unable to use the telephone.
   - ☐ NA - Patient does not have a telephone.

15. **(M0780) Management of Oral Medications:** Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
   - ☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
   - ☐ 1 - Able to take medication(s) at the correct times if:
     (a) individual dosages are prepared in advance by another person; OR
     (b) given daily reminders; OR
     (c) someone develops a drug diary or chart.
   - ☐ 2 - Unable to take medication unless administered by someone else.
   - ☐ NA - No oral medications prescribed.

16. **(M0790) Management of Inhalant/Mist Medications:** Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**
    - ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
    - ☐ 1 - Able to take medication at the correct times if:
        (a) individual dosages are prepared in advance by another person, OR
        (b) given daily reminders.
    - ☐ 2 - Unable to take medication unless administered by someone else.
    - ☐ NA - No inhalant/mist medications prescribed.

17. **(M0800) Management of Injectable Medications:** Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
    - ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
    - ☐ 1 - Able to take injectable medication at correct times if:
        (a) individual syringes are prepared in advance by another person, OR
        (b) given daily reminders.
    - ☐ 2 - Unable to take injectable medications unless administered by someone else.
    - ☐ NA - No injectable medications prescribed.

18. **(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies):** Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**
    - ☐ 0 - Patient manages all tasks related to equipment completely independently.
    - ☐ 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
    - ☐ 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
    - ☐ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
    - ☐ 4 - Patient is completely dependent on someone else to manage all equipment.
    - ☐ NA - No equipment of this type used in care **[If NA, go to *Section I - Emergent Care*]**

19. **(M0820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies):** Caregiver's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**
    - ☐ 0 - Caregiver manages all tasks related to equipment completely independently.
    - ☐ 1 - If someone else sets up equipment, caregiver is able to manage all other aspects.
    - ☐ 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.
    - ☐ 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
    - ☐ 4 - Caregiver is completely dependent on someone else to manage all equipment.
    - ☐ NA - No caregiver

I. EMERGENT CARE

1. **(M0830) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**
    - ☐ 0 - No emergent care services **[If no emergent care, go to *Section J - Inpatient Facility Admission or Discharge*]**
    - ☐ 1 - Hospital emergency room (includes 23-hour holding)
    - ☐ 2 - Doctor's office emergency visit/house call
    - ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites)
    - ☐ UK - Unknown **[If UK, go to *Section J - Inpatient Facility Admission or Discharge*]**

2. **(M0840) Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**
    - ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
    - ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
    - ☐ 3 - Injury caused by fall or accident at home
    - ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
    - ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
    - ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
    - ☐ 7 - Hypo/Hyperglycemia, diabetes out of control
    - ☐ 8 - GI bleeding, obstruction
    - ☐ 9 - Other than above reasons
    - ☐ UK - Reason unknown

J. INPATIENT FACILITY ADMISSION OR DISCHARGE FROM HOME CARE

1. **(M0855)** To which **Inpatient Facility** has the patient been admitted? **(Choose only one answer.)**

☐ **1** - Hospital ☐ **2** - Rehabilitation facility ☐ **3** - Nursing home ☐ **4** - Hospice ☐ **NA** - No inpatient facility admission

↓

2. **(M0890)** If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

☐ 1 - Hospitalization for emergent (unscheduled) care
☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
☐ UK - Unknown

↓

(M0895) Reason for Hospitalization: (Mark all that apply.)

☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
☐ 2 - Injury caused by fall or accident at home
☐ 3 - Respiratory problems (SOB, infection, obstruction)
☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
☐ 5 - Hypo/Hyperglycemia, diabetes out of control
☐ 6 - GI bleeding, obstruction
☐ 7 - Exacerbation of CHF, fluid overload, heart failure
☐ 8 - Myocardial infarction, stroke
☐ 9 - Chemotherapy
☐ 10 - Scheduled surgical procedure
☐ 11 - Urinary tract infection
☐ 12 - IV catheter-related infection
☐ 13 - Deep vein thrombosis, pulmonary embolus
☐ 14 - Uncontrolled pain
☐ 15 - Psychotic episode
☐ 16 - Other than above reasons

↓

[Go to *#5 - Most Recent Home Visit Date*]

[Go to *#5 - Most Recent Home Visit Date*]

↓

3. **(M0900)** For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

☐ 1 - Therapy services
☐ 2 - Respite care
☐ 3 - Hospice care
☐ 4 - Permanent placement
☐ 5 - Unsafe for care at home
☐ 6 - Other
☐ UK - Unknown

↓

[Go to *#5 - Most Recent Home Visit Date*]

[Go to *#5 - Most Recent Home Visit Date*]

↓

4. **(M0870) Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**

☐ 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility) **[Go to next question - *Services or Assistance*]**
☐ 2 - Patient transferred to a noninstitutional hospice **[Go to *#5 - Most Recent Home Visit Date*]**
☐ 3 - Unknown because patient moved to a geographic location not served by this agency **[Go to *#5 - Most Recent Home Visit Date*]**
☐ UK - Other unknown **[Go to *#5 - Most Recent Home Visit Date*]**

↓

(M0880) After discharge, does the patient receive health, personal, or support **Services or Assistance**? **(Mark all that apply.)**

☐ 1 - No assistance or services received
☐ 2 - Yes, assistance or services provided by family or friends
☐ 3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)

↓

[Go to *#5 - Most Recent Home Visit Date*]

5. **(M0903) Date of Last (Most Recent) Home Visit:**

__ __ – __ __ – __ __ __ __
m m d d y y y y

6 **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

__ __ – __ __ – __ __ __ __
m m d d y y y y

DISCHARGE ASSESSMENT

Client's Name:

Client Record No.

K. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE

1. Identified Problem	Interventions	Current Status

2. Overall Status at Discharge:

Copy of Summary to: ☐ Referral Source ☐ Attending Physician

Date of Assessment: _____ Signature of Assessor: _____

DEATH AT HOME

Client's Name:

Client Record No.

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

1. **(M0080) Discipline of Person Completing Assessment:**

   ☐ 1 - RN ☐ 3 - SLP/ST
   ☐ 2 - PT ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

3. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

   Start/Resumption of Care
   - 1 - Start of care—further visits planned
   - 3 - Resumption of care (after inpatient stay)

   Follow-Up
   - 4 - Recertification (follow-up) reassessment
   - 5 - Other follow-up

   Transfer to an Inpatient Facility
   - 6 - Transferred to an inpatient facility—patient not discharged from agency
   - 7 - Transferred to an inpatient facility—patient discharged from agency

   Discharge from Agency — Not to an Inpatient Facility
   - ☐ **8 - Death at home**
   - 9 - Discharge from agency

4. **(M0906) Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

B. SUMMARY OF CARE PROVIDED DURING HOME CARE EPISODE:

Date of Assessment: _____ Signature of Assessor: _____

SAMPLE CLINICAL ASSESSMENT FORM FOR ALL TIME POINTS (INCORPORATING OASIS-B1 [12/2002] DATA SET)

This sample assessment form incorporates the OASIS-B1 (12/2002) data items for all time points into one document. This assessment form was created in response to requests from the home health industry, so that agencies could provide one document to clinicians that could be used for any of the required assessment time points (start/resumption of care, follow-up, transfer to inpatient facility, death at home, and discharge). Consistent with the Conditions of Participation regarding the comprehensive assessment, the OASIS items have been integrated into other items that would typically be included in a comprehensive patient assessment.

Those familiar with OASIS items know that the text or responses for several OASIS items change at different time points, and some items are not required for all time points. Use of this form will require that the clinician carefully follow skip instructions denoting the various time points. To assist in this "skip" process, icons representing start/resumption of care, follow-up, transfer, and discharge have been printed in the form. These icons are identified in a legend at the top of each page.

When utilizing this form, agencies should carefully review accepted professional standards and relevant agency policies regarding clinical documentation with their staff. In particular, standards and policies concerning noncompleted items should be addressed. For example, when the form is used for a transfer to an inpatient facility, several pages of the assessment form will not be completed. Professional standards and agency policy should inform the clinician how to proceed in this instance.